Oh, My Aching 724.2

By Buzz McClain
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Last year I had a 724.5—actually, it was more of a 724.2—and paid a 99395 for a V70.0, which I hadn't had in a while. But after hearing about my back my doctor referred me to an orthopedic surgeon who sent me to an imaging center for a 72148.

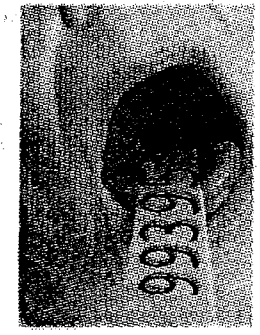
The pictures were not good. The surgeon concluded I had a 722.10. No amount of 19458-0456-1, as splendid as it is, was going to fix this. So he performed a 63030, which required follow-up J3490 (because I'm a weenie) and a month of 97110.

Unless you are one of the 2,200 "coders" who attended this month's American Academy of Professional Coders (AAPC) conference at the Washington Convention Center, chances are you need a translation. A 724.5 is a pain in the back, and a 724.2 is a pain in the lower back. A 99395 is an office visit of preventive nature to a primary care provider; a V70.0 is a routine checkup. The orthopedic surgeon suspected I had a herniated lumbar disc (722.10) and sent me to get an MRI (72148). Massive doses of ibuprofen (19458-0456-1) might mask the pain but not cure the ailment.

So I had a discectomy (63030), followed up with a course of painkillers (J3490) and physical rehabilitation (97110).

You may not know your 565.0 from a hole in the ground, but the coders have this numerical nomenclature down pat.

Professional coders work in doctors' offices, hospitals, insurance companies and other establishments and provide a very important function: Without them, your insurance company wouldn't be sure what your doctor did, or how much to pay for what was done.



Indeed, coders have a code for everything.

" 'Assault by letter bomb'—isn't that cool?" says Jean Stoner, manager of coding operations at Code Ryte, a software firm in Bethesda, citing one of her favorite obscure injury codes. She's been turning human body parts, diseases, diagnoses, courses of treatments and general medical mayhem into numbers since 1986, and she still finds thrills in

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A Number for Every Ill You Can Imagine—and Some You Can't

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the endless variety of maladies that need to be turned into digits.

" 'Assault by submersion,' that's a good one," she says. There also are codes for "pedestrian hit by an ox cart" (E827.0), "steam shovel accident" (E919.7) and, more provocatively, "launch pad accident" (E845.0).

These "E codes," which are listed in the ICD-9-CM ("International Classification of Diseases—9th Edition-Clinical Modification"), one of several industry bibles, explain the patient's ailment.

To describe what the doctor did to remedy a disorder, Stoner says, one would turn to the CPT-4 ("Current Procedural Terminology, 4th Edition"). "Did they do an X-ray of the chest, did they do an ultrasound?" asks Stoner. "Then the ICD-9 is the book that explains why they did what they did: What was the diagnosis the patient had? They had a cholecystectomy because they have colelithisasis—gallbladder stones. That's 574.2. I see that one a lot."

Then there are the HCPCS codes—"H.. Common Procedure Coding System," the "H" standing for the Health Care Financing Administration (HCFA). Those are the codes for filing Medicare and Medicaid claims. (HCFA is now CMS, the Centers for Medicare and Medicaid Services, part of the U.S. Department of Health and Human Services.)

Coders have been around since the 1960s, but new technologies and government policies have kept the field growing. The AAPC has some 26,000 members, says Clare Bailey, marketing manager for the Salt Lake City-based organization. But, she adds, "there's a real shortage of them now."

In doctors' offices, the receptionist or another staff person often does double duty as the coder. (And the task usually goes to a woman: Only 5 percent of the AAPC's coders are men.) The physician hands over the medical charts, and the employee turns the medical terminology into codes.

"It's trial-and-error and, of course, we don't recommend that," says Bailey, whose organization trains and certifies coders. If incorrect codes are submitted for reimbursement, payment is slowed down or challenged by the insurance provider.

"With all the fraud and abuse cases out there, it helps the doctor that the coders are trained so that he doesn't have to worry about that," Bailey says. "He needs to spend his time helping patients instead of worrying about filling out forms."

AAPC-certified coders make an average of $40,674 annually; noncertified coders average $30,790. Among both groups, salaries are generally higher for coders who work for larger practices. Some coders can make substantially more as consultants ($50,245) or speakers ($45,800).

One of the buzzwords at the conference was HIPAA, the Health and Insurance Portability and Accountability Act of 1996. This law was designed to make it easier for everyone in the industry to exchange data, which means everybody has to adopt the same codes.

Before HIPAA was enacted, says Karen Trudel, director of CMS's HIPAA project staff, "each one of those [insurance] plans had their own proprietary electronic formats, their own rules, their own code sets—and the poor person in the back office filling out all those claims had to keep all that straight."

As more transactions between providers and payers become electronic, patients' medical records could be jeopardized. To prevent this, HIPAA also provides privacy and security provisions. CMS is ready to begin using the new transaction standards—the set of codes everybody agrees to use—but full compliance with the rules is not required until October of 2003.

Not only will the standardization of codes make things easier for providers and payers, but CMS estimates that $1.5 billion will be saved in the first five years, a benefit that will be shared "pretty much by the whole health care industry," says Trudel.

Of course, no change comes without some resistance. Converting a medical office to standardized coding "can be very traumatic," says Trudel. "You have to get new code books, train new coders, learn new codes, and it has a significant impact throughout a practice."

And if Andy Kapit has his way, coders themselves will be victims of simplification. Kapit is the CEO of Code Ryte, which is working on software that automatically pulls words from the physician's electronic medical records and determines the proper codes for the complaint, the diagnosis and the treatment. In other words, this software eliminates the coder.

"It's operational right now," Kapit says. "We're currently using it in radiology and will release other medical specialties on a fairly regular basis."

And how do coders feel about this threat to their future?

"They don't like it," says Code Ryte's Jean Stoner. "We don't have booths at this trade show, I'll tell you that." ■

Buzz McClain has written for the Health section about getting a botulism toxin treatment and avoiding muscle strain while exercising.